3 Midlevel Practitioner Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers Medicaid services provided by midlevel practitioners as deemed appropriate by IDHW. This includes certified registered nurse anesthetists (CRNA), physician assistants, certified nurse midwives, and nurse practitioners.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.1.2 Prior Authorization

If prior authorization for a service is required, the prior authorization number must be indicated on the claim or the service will be denied.

For Healthy Connections clients, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

3.1.3 Place of Service Codes

Idaho Medicaid follows national place of service codes. Refer to the Current Procedural Terminology (CPT). Enter the appropriate numeric code in the place of service box on the CMS-1500 claim form.

3.1.4 Reimbursement

Medicaid reimburses midlevel practitioner services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Idaho Medicaid will reimburse the lowest of the following rates:

- Provider's actual charge for the service
- Medicaid's established maximum allowable reimbursement from its pricing file for the service. Most mid-level reimbursement is 85% of the physician fee schedule as posted on the physician fee schedule.
- Reimbursement for Medicare crossover claims is based on the Medicaid allowed amount and will be the lower of the Medicare allowed amount, the Medicaid allowed amount, or the billed amount.

3.1.5 Procedure Codes

Idaho Medicaid follows national procedure codes as listed in the most current version of:

- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)

If a non-specific CPT code is used and the Medicaid medical consultant determines a listed CPT code exists that accurately describes the procedure performed, the claim may be denied.

3.2 CRNA Services Policy

3.2.1 Covered Services

Medicaid accepts anesthesia codes from the anesthesia section of the CPT manual.

Payments may be made directly to the Certified Registered Nurse Anesthetists (CRNA) under their individual provider numbers when billed on the CMS-1500 form. When a CRNA provides services through hospitals or anesthesiologists groups, the hospital or group may bill Medicaid for the CRNA. Hospitals with a Medicare exception may bill for CRNAs on a UB-92.

To enroll as a participating CRNA, the hospital or group must send EDS an application with a copy of the valid CRNA license attached.

3.2.2 Anesthesia Time

Anesthesia time begins when the CRNA physically starts to prepare the client for the induction of anesthesia in the operating room and ends when the CRNA is no longer in constant attendance.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or a CRNA, is paid 100% of the allowed amount for the procedure.

3.2.3 Billing Instructions

Enter the CPT anesthesia code for the surgical procedure that was performed on the client, total amount of time in minute increments, and any necessary modifiers from Section 3.2.4 Modifiers.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. A repeat anesthesia procedure on the same day which is billed with the CPT modifier 76 or 77 will be paid at $0.00. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT anesthesia codes plus the total time for both sessions, with adequate documentation.

3.2.4 Modifiers

Up to four (4) modifiers may be used. No additional payment is made for these modifiers.

Modifier	Description
AA	Anesthesia services personally performed by an anesthesiologist. The -AA modifier is used for all basic procedures.
P1	Normal healthy patient
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life
P5	Moribund patient who is not expected to survive without the operation

Modifier	Description
QS	Monitored anesthesia care service (can be billed by CRNA or a physician/osteopath). This modifier for monitored anesthesia care (QS)is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service; with medical direction by a physician.
QZ	CRNA service; without medical direction by a physician.

Modifier **22** should not be used with, or in place of, the appropriate modifier(s) when billing unless the services would require the use of more than three (3) of the modifiers listed above. Make certain that you use the CPT anesthesia code that most accurately describes the procedure performed. The use of modifier 22 overrides any other modifier indicated.

3.3 Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner Services Policy

3.3.1 Overview

All state-licensed physician assistants, certified nurse midwives, and nurse practitioners are eligible to participate in the Idaho Medicaid program. They must obtain an Idaho Medicaid provider number from EDS.

All eligible midlevel practitioners must submit an application for provider enrollment to EDS for approval before billing for services rendered to Idaho clients.

See **Section 1, *General Provider and Client Information*** for more information on provider enrollment.

3.3.2 Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional as a physician service is prohibited.

3.3.3 Out-of-state Care

Out-of-state providers who are enrolled in the Idaho Medicaid program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid clients without receiving out-of-state prior approval.

All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho.

3.3.4 Medical Policy Restrictions

3.3.4.1 Elective Treatment

Prior authorization is required for all elective (not medically necessary) medical and surgical procedures. Procedures that are generally accepted by the medical community as medically necessary may require prior authorization to be eligible for payment. To inquire whether a procedure requires prior authorization contact EDS in Boise at (208) 383-4310 or (800) 685-3757.

3.3.4.2 Injectable Vitamins

Payment for injectable vitamin therapy must be supported by the diagnosis of pernicious anemia. Injectable vitamin therapy is limited to the following:

- Vitamin B12 and its analogues
- Vitamin K and its analogues
- Folic acid
- Vitamin B12 mixtures, folic acid, and iron salts in any combination

See Section 1, General Provider and Client Information for more information on provider enrollment.

3.3.5 Coverage Limits

3.3.5.1 Cosmetic Surgery

All cosmetic surgery is excluded from payment unless it is found to be medically necessary and has Medicaid prior authorization.

3.3.5.2 Obesity

Surgery for the correction of obesity is covered only with prior authorization from the Qualis Health. If approval is given, Qualis Health will issue the authorization number and perform any length of stay review that is necessary. Surgical procedures for weight loss will be considered when the client meets the criteria for morbid obesity as defined in the *Rules Governing the Medical Assistance Program*, IDAPA 16.03.09.069, and the client has one of the major life threatening complications of obesity, alveolar hypoventilation, uncontrolled diabetes, or uncontrolled hypertension.

For purposes of this subsection, "uncontrolled" means that there is inadequate compliance or response to a prescribed medical regimen. Other complications of obesity such as orthopedic treatment, skin and wound care are not considered justification for a surgical remedy.

Clients must have a psychiatric evaluation to determine the stability of personality at least three months prior to the date the surgery is requested. The client must understand and accept the resulting risks associated with the surgery.

All clients requesting surgery must have their physician/osteopath send a complete history and physical exam, and medical records documenting the client's weight and efforts to lose weight by conventional means over the past five years, for the request to be considered.

The documentation of life threatening complications in subsection 03.09.069.01.a of the *Rules Governing the Medical Assistance Program* must be provided by a consultant specializing in pulmonary diseases, endocrinology, cardiology or hypertensive illness who is not associated by clinic or other affiliation with the surgeons who will perform the surgery, or the primary physician/osteopath who refers the client for the procedure.

Abdominoplasty or panniculectomy is covered only with prior authorization from the Qualis Health. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, the following:

- Photographs of the front, side, and underside of the client's abdomen
- Documented treatment of the ulceration and skin infections involving the panniculus
- Documented failure of conservative treatment, including weight loss
- Documentation that the panniculus severely inhibits the client's walking
- Documentation that the client is unable to wear a garment to hold the panniculus up
- Documentation of other detrimental effects of the panniculus on the client's health such as severe arthritis in the lower body

3.3.5.3 Unproven/Questionable Procedures

New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare program are excluded from payment by Medicaid.

3.3.5.4 Complications

The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening.

3.3.5.5 Acupuncture

Acupuncture is not covered.

3.3.5.6 Naturopathic Services

Naturopathic services are not covered.

3.3.5.7 Biofeedback Therapy

Biofeedback therapy is not covered.

3.3.5.8 Fertility Related Services

Fertility-related services, including testing, are not covered.

3.3.5.9 Laetrile Therapy

Laetrile therapy is not covered.

3.3.5.10 Examinations

Wellness physicals for adults 21 years of age and over:

Wellness physicals, special reports, and pre-employment physicals for individuals age twenty-one (21) and older and pre-employment physicals are not covered by Idaho Medicaid. The one exception is if the physical is an annual health risk assessment/preventative physical examination for an adult as recommended by Idaho Medicaid.

When an exam and/or report is required by the Department for an adult client, including annual history and physical exams for adults living in an ICF/MR facility, use one of the following two CPT codes with the ICD-9 primary diagnosis code V70.3:

- 99450 – Basic Life and/or disability examination that includes: History and Physical and completion of necessary documentation.
- 99080 – Special Reports-more than the information conveyed in the usual medical communications or standard reporting form. This code should be used when the provider can complete the Department required History and Physical information from past records rather than a new examination.

Adult preventive medicine procedures will be limited to one per rolling year. Evaluation and Management procedures will not be paid on the same day as a preventive medicine procedure for participants over age 21. Preventive

Medicine procedures billed for participants over age 21 **must** be billed with diagnosis code V70.0 or the claim will be denied. Bill the appropriate procedure for the participant's age as listed below:

- 99385 – New Patient Preventive Medicine Examination – Adult Age 18-39
- 99386 – New Patient Preventive Medicine Examination – Adult Age 40-64
- 99387 – New Patient Preventive Medicine Examination – Adult Age 65+
- 99395 – Established Patient Preventive Medicine Examination – Adult Age 18-39
- 99396 – Established Patient Preventive Medicine Examination – Adult Age 40-64
- 99397 – Established Patient Preventive Medicine Examination – Adult Age 65+

Wellness physicals for children up to the age of 21:

Routine physicals such as pre-school, school, summer camp, Special Olympics or sports examinations for individuals up to the age of twenty-one (21) are covered with diagnosis V70.3 as long as one of the above reasons is listed on the claim form. The provider must use the Preventive Medicine procedure codes and diagnosis code **V20.1** or **V20.2** when billing for wellness physical exams.

Health risk assessment physicals for children are covered based on the EPSDT periodicity requirements.

3.4 Emergency Department/Critical Care Services

3.4.1 Overview

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled temporary services to clients who come in for immediate medical attention. The facility must be available 24 hours a day.

Idaho Medicaid limits clients to six emergency department visits per calendar year, unless is the client is enrolled in Healthy Connections. If the client is admitted to the hospital from the emergency department this visit is not counted in the six emergency visits per year.

Use codes 99281-99285 to report evaluation and management services provided in the emergency department. No distinction is made between new and established clients in the emergency department.

3.4.2 Critical Care Services

Critical care includes the care of critically ill clients in a variety of medical emergencies that requires the constant attention of the physician/osteopath or midlevel practitioner. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician/osteopath providing critical care:

- interpretation of cardiac output measurements
- interpretation of chest x-rays
- pulse oximetry
- blood gases, and information data stored in computers (e.g., ECG, blood pressure, hematologic data
- gastric intubation
- temporary transcutaneous pacing
- ventilator management
- vascular access procedures

The critical care codes are used to report the total duration of time spent by a physician/osteopath providing constant attention to a critically ill client.

Use code 99291 for critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injuries or comatose client, requiring the prolonged presence of the physician/osteopath.

This code is used to report the first 30-74 minutes of critical care on a given day. 99291 is one unit. It should be used only once per day even if the time spent by the physician/osteopath or midlevel practitioner is not continuous on that day. 99291 is paid to only one physician/osteopath or midlevel practitioner per day unless the client is transferred from one facility to another.

Use code 99292 to bill each additional 30 minutes of critical care. This code is used to report each additional 30 minutes beyond the first 74 minutes. Bill code 99292 in 30 minute units.

3.4.3 Other Procedures

Other procedures which are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

3.4.4 Prolonged Services

Use codes 99354-99357 when a midlevel practitioner provides prolonged service involving direct (face-to-face) client contact that is beyond the usual service in an inpatient or outpatient setting.

Use code 99354 or 99356 to report the first hour of prolonged service on a given date, depending on the place of service. Prolonged service lasting less than 30 minutes on a given date is not separately reported, because the work involved is included in the evaluation and management codes.

Use code 99355 or 99357 to report each additional 30 minutes beyond the first hour, depending on the place of service. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

3.5 Obstetric Care

3.5.1 Overview

Medicaid covers total obstetrical care, including:

- Antepartum care
- Delivery (certified nurse midwife only)
- Postpartum care

Obstetric care must be billed as a global charge unless the attending physician did not render all components of the care. Antepartum care may be billed separately from the delivery and postpartum care only when the services were rendered by different group or billing physicians/osteopaths.

High risk pregnancy case management services are now available to support providers in caring for Idaho Medicaid patients. Pregnant women who are at risk for premature labor or congenital issues of the fetus may be referred to a Qualis Health Case Manager, who will telephonically assist with the coordination of in-home and community support services. To make a referral:

- Contact Qualis Health at (800) 783-9207 and request case management services
- A nurse case manager will send a packet of information to the patient with information about the voluntary, no-cost service.
- If the patient wishes to participate, she will return the signed form to Qualis Health.

3.5.2 Total OB Care

Total OB care includes cesarean section or vaginal delivery, with or without episiotomy, with or without forceps or breech delivery.

Charges for total obstetric care must be billed after the delivery. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB clients. If the client is new to the office, a new client office visit code should be used. The initial examination must be identified as such and billed with the appropriate E/M CPT code.

Prenatal diagnostic laboratory charges, such as a complete urinalysis, should be billed as separate charges using appropriate CPT codes. If an outside laboratory, not the clinic, performed the services, the lab must bill Medicaid directly.

Resuscitation of the newborn infant is covered separately if billed under the child's name and MID number.

3.5.3 Place of Service Code

The place of service code for total obstetric care is normally 21 – inpatient, and must be on the claim form in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.5.4 Antepartum Care

Antepartum care includes the following usual prenatal services:

- Recording weight, blood pressure, fetal heart tones
- Routine dipstick urinalyses
- Maternity counseling

3.5.4.1 Billing for Incomplete Antepartum Care

If the physician/osteopath or mid-level sees the client for part of the prenatal care but does not deliver, submit charges only for the services delivered.

When billing for the initial physical examination and the second or third follow up visit, use the appropriate E/M CPT code. Any laboratory services not previously submitted can be billed using the appropriate CPT procedure code. Do not bill for lab charges sent to an outside laboratory. Bill only for the services rendered.

When billing for four to six prenatal visits, use CPT code 59425 with the total charge for all visits on one line. Do not split-out each visit. Enter the first date of service in the “from date” field on the CMS 1500 claim form and the last date of service in the “to date” field. Note the date for each visit that falls between the “from date” of service and the “to date” of service in the comment field on the CMS 1500 claim form or the electronic claim form. These services must be split out to different claims when the client is not on the Healthy Connections program the whole time.

When billing for seven or more prenatal visits with or without an initial visit, use CPT code 59426 with the total charge and the description “Antepartum Care Only” on one line with one charge. Note the date for each visit that falls between the “from date” of service and the “to date” of service in the comments field of the CMS 1500 claim form or the electronic claim form. These services must be split out to different claims when the client is not on the Healthy Connections program the whole time.

3.5.5 Postpartum Care

Postpartum care includes hospital and office visits in the 45-days following vaginal or cesarean section delivery. Postpartum care also includes contraceptive counseling.

3.6 Presumptive Eligibility/ Pregnant Women

The Presumptive Eligibility (PE) and the Pregnant Women (PW) programs are outlined in Section 1, General Provider and Client Information, Presumptive Eligibility, and Pregnant Women. Please refer to Benefit Plan coverage under these sections for more information. Section 1 is available online at:
http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=569&MId=10826&wversion=Staging

3.6.1 Billing for PE Determinations

To bill for the completion of a PE determination, follow these procedures:

- Client and provider complete program questions and determine if client is eligible for the PE program. Provider sends the application for services to the client's field office.
- Client's local field office processes client's application for services and issues a number for the client's Presumptive Eligibility (PE) eligibility period.
- Client's PE period ends after a maximum coverage period of 45 days, or sooner if the candidate is eligible for PW (Pregnant Women) or another Medicaid program.
- Client's eligibility must be verified by the provider using MAVIS or electronic software. See Section 1 of the provider manual, *General Provider and Client Information*, for instructions on verifying eligibility. Section 1 may also be accessed online at:
  http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=569&MId=10826&wversion=Staging
- Use HCPCS code T1023 to bill for PE determination.
- Include the client's full name, Medicaid ID number and date of birth.

The PE program covers only outpatient ambulatory pregnancy related services. A delivery cannot be billed under the Presumptive Eligibility program regardless of the setting.

Payment for the PE client appears on the Remittance Advice (RA) with the client's correct Medicaid Identification Number and not the special billing number, 9999999, under which the claim was submitted.

3.6.1.1 Billing for PE or PW Services

Billings for PE or PW clients should follow the same billing practices as those for any pregnant Medicaid client.

Services rendered must be a direct result of or directly affect the pregnancy.

Prenatal clinics can bill only the special services procedure codes and laboratory services under the prenatal clinic provider number.

See **Section 1.4** for more information on medical necessity.

A Medical Necessity – Pregnancy Related Form is included in the Forms Appendix of this handbook.

3.6.2 Billing for Twin Deliveries

Delivery of first baby should be billed with the appropriate CPT code, 1 unit, and only the charges for the first delivery. Delivery of the second baby should be billed with a delivery code (**59409, 59514, 59612 or 59620**), modifier 51, 1 unit, and only the charges for the second delivery. All antepartum or postpartum care should be included in the delivery code for the first baby.

3.6.2.1 Medical Necessity Form

The PE and PW programs are for pregnancy-related services only. If the services rendered are not clearly pregnancy related, a Medical Necessity Form which justifies how they are pregnancy related must accompany the claim.

All services that are not clearly pregnancy related must have supporting documentation to justify the service. Each claim is reviewed on a case-by-case basis by the EDS Medical Consultant. If a claim is denied with an EOB code that states “This PW client’s charge has been reviewed by the EDS Medical Consultant and denied,” you can request further review from Medicaid.

Send appeals to:

Idaho Medicaid
Bureau of Medical Care
P.O. Box 83720
Boise, ID 83720-0036

3.7 Family Planning Services

3.7.1 Overview

Family planning includes counseling and medical services prescribed or performed by a midlevel practitioner. Specific items covered are services for diagnosis, treatment, related counseling, and restricted sterilization.

3.7.2 Contraceptive Supplies

Medicaid will pay for contraceptive supplies including prescription diaphragms, intrauterine devices, implants, injections, contraceptive patches, and oral contraceptives.

3.7.2.1 Limitations

Payment for oral contraceptives is limited to the purchase of a three-month supply when purchased through a pharmacy.

Payment to providers of family planning services is limited to the Department's fee schedule.

Medicaid does not pay a midlevel practitioner for take-home contraceptives, except those inserted or fitted by the provider, such as an IUD, Norplant, or diaphragm.

3.7.2.2 IUD

When billing for IUDs, use the following procedure codes (with modifier FP):

J7300 Intrauterine copper contraceptive

J7302 Mirena IUD

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

When billing J codes, the appropriate NDC must be billed with the procedure code. Medicaid pays for the IUD insertion, but does not cover any separate fees for the office exam. However, an office exam may be billed at the time of insertion if the client was treated for an unrelated diagnosis. Attach modifier 25 to the E/M CPT code.

3.7.2.3 Norplant

Norplant contraceptive services must be billed using the following procedure codes (with modifier FP):

11975 Insertion, implantable contraceptive capsules

11976 Removal, implantable contraceptive capsules

11977 Removal with reinsertion, implantable contraceptive capsules

J7306 Levonorgestrel (contraceptive) implants system, including implants and supplies (Norplant kit)

3.7.2.4 Depo-Provera and Lunelle Injectables

Depo-Provera and Lunelle injectables must be billed using the following procedure codes (with modifier FP):

- J1055 Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Depo-Provera)
- J1056 Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Lunelle)

When Depo-Provera is used for any purpose other than contraception or for dosages up to 100 mg, use J3490 unclassified drug and indicate the NDC (National Drug Code), quantity dispensed, and units of measure. See Section 3.18.6.3 or Medicaid Information Release MA03-69 for more information.

3.7.2.5 Diaphragms

When billing for a diaphragm, use the following codes (with modifier FP):

A4266 Diaphragm for contraceptive use

57170 Diaphragm or cervical cap fitting with instructions

3.7.3 Family Planning Diagnoses/Modifier

Any services provided as part of a family planning visit should include one of the diagnoses listed in the table below as the primary diagnosis. Include the modifier FP (family planning) with the CPT E&M code. Using the FP modifier with the correct diagnosis saves Idaho Medicaid dollars, and eliminates the need for a Healthy Connection referral.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V24.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, insertions, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other unspecified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.8 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

3.8.1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program was designed to provide periodic screening of Medicaid eligible children for early detection of medical and developmental problems. The primary components of EPSDT are the medical screen, the developmental screen, and the dental screen. EPSDT screen codes can be used to bill for preschool, school, summer camp, Special Olympics, or sports physicals.

3.8.2 Billing

EPSDT services must be billed with Preventive Medicine CPT codes and, if applicable, an EPSDT modifier.

3.8.3 Medical Screen Eligibility

All Medicaid eligible children ages birth through the last day of the month of their twenty-first (21) birthday are eligible for EPSDT screens. Parents periodically receive an informational letter reminding them the child is due to have an EPSDT screen.

Medicaid follows the American Academy of Pediatrics Periodicity Schedule. The screen must include the appropriate laboratory tests for that periodicity schedule. All EPSDT services are based on guidelines established by CMS. See **Section 1, General Provider and Client Information**, for the complete periodicity schedules.

3.8.4 Components of an EPSDT Screen

The screening must include the appropriate laboratory tests for that periodicity schedule:

- History, including a comprehensive health and developmental history including assessment of both physical and mental health development.
- Physical exam: a comprehensive unclothed physical examination including a visual inspection of mouth and teeth.
- Laboratory: Federal mandate requires a screening for lead poisoning as a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and again at 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.
- Health education, including anticipatory guidance. Health education and counseling to both parents (or guardians) and children is required and designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- Immunization review must be appropriate to age and health.

See **Section 1.5.5.4 EPSDT Screening and Immunization Schedule** for the complete schedule of age-appropriate health history and health screening services.

3.8.5 Payment

Medicaid reimburses EPSDT screens on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

3.8.6 Modifiers

Modifier	Description
U6	Patient is referred to another provider.
No replacement modifier	Not applicable.
EP	Service provided as part of Medicaid EPSDT program.
25	(Description change only): Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

3.8.7 Diagnosis Code

Use diagnosis code **V20.1** — Other Healthy Infant/Child, or **V20.2** — Routine Infant or Child Health Check for all EPSDT screening claims.

3.9 Other Billing Procedures

3.9.1 Consultations

A consultation is a type of service provided by a physician assistant whose opinion or advice regarding evaluation and/or management of a specific problem is requested by a physician or other appropriate source. A physician assistant consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

Note: Phone consultations are not a payable service by Medicaid.

The written or verbal request for a consultation from the attending physician or other appropriate practitioner and the need for the consultation must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated by written report to the requesting physician or other appropriate source.

If a consultant subsequently assumes responsibility for management of a portion or all of the client's condition(s), the follow-up consultation codes should not be used. In the hospital setting, the physician assistant receiving the client for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established client code should be used

3.9.2 Assist-at-Surgery

In order to recognize assistant-at-surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed with modifier AS.

Note: All unlisted CPT codes must have a description on the claim form.

AS Physician Assistant or nurse practitioner services for assistant-at-surgery (Medicare Part B bulletin GR99-3)

3.9.3 Foster Care

Program enrollment physicals for foster children are eligible for payment by Medicaid. Refer to Section 3.3.5.10 for billing guidelines.

3.9.4 PKU Testing

Newborn Screening Kits (PKU) are a covered benefit of the Idaho Medicaid Program. Test kits are ordered through the Idaho Newborn Screening Program and must be purchased in advance from:

Idaho Newborn Screening Program
450 West State Street, 4th Floor
P.O. Box 83720
Boise, ID 83720-0036

Phone: (208) 334-4927

Bill Idaho Medicaid with procedure code S3620.

3.9.5 Collection Fees

Collection of a lab specimen for a client is not payable in an office setting.

3.9.6 Allergy Injections

Office calls are included in the reimbursement for allergy injections.

3.10 Immunizations

Most vaccines provided come through the Vaccines for Children (VFC) Program from the Department of Health and Welfare's Division of Health. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use.

When billing for a client who has both private insurance and Medicaid, bill the private insurance first using its billing instructions. After receiving the EOB from the primary insurance indicating partial or no payment, submit the EOB with the claim to Medicaid using the instructions below.

Medicaid should be billed for the administration of state-supplied vaccines according to the service(s) rendered at the time the vaccine(s) was administered. Medicaid uses the most current version of the CPT guidelines.

Providers should bill their UCR (usual and customary rate) for administration of vaccines, provider-purchased vaccines, and E/M services.

3.10.1 State-Supplied Vaccines

When only a free vaccine(s) is administered, the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier SL billed at a zero dollar amount ($0.00); and
- Administration code 90471 with modifier U7 (one unit only)

3.10.1.1 Administration of State-Supplied Vaccine with E/M Visit

When a free vaccine(s) is administered in conjunction with an E/M visit, the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier SL billed at a zero dollar amount ($0.00); and
- Administration code 90471 with modifier U7 (one unit only); and
- The appropriate CPT code for the E/M visit with modifier 25.

In order to bill the E/M code, documentation in the client's record must reflect that additional services were rendered at the time the vaccine was given. If reporting E/M visit with CPT 99201 or 99211, the administration (90471) is not separately billable but is considered inclusive within the E/M.

Administration of a Provider-Purchased Adult Vaccine with or without an E/M Visit

When an injection or adult vaccine is administered in conjunction with an E/M visit, Medicaid will pay only for the E/M visit and the vaccine. The administration of the vaccine is inclusive within the E/M and is not separately billable. Services provided should be billed at the UCR. The Medicaid claim must include the following information:

- The appropriate CPT or five-digit HCPCS code for the injectable vaccine;
- If applicable, the appropriate E/M CPT code billed at the UCR; **and**

- If administering a provider-purchased adult vaccine without an E/M visit, bill with the CPT/HCPCS for the vaccine and 90471 and/or 90472, as appropriate.

3.10.1.2 Administration of Provider-Purchased Childhood Vaccine With or Without an E/M Visit

This should only occur when a free vaccine is not available. Services provided should be billed at the UCR. When a provider-purchased childhood vaccine is administered to a child less than twenty-one (21) years old, the Medicaid claim must include the following information:

- The appropriate CPT or five-digit HCPCS code for the injectable vaccine;
- Administration code 90471 for the first vaccine and 90472 for each additional vaccine; and
- If applicable, the appropriate E/M code with modifier 25.

In order to bill the E/M code, documentation in the client's record must reflect that additional services were rendered at the time the vaccine was given

3.10.1.3 Administration of an Injection that is Part of a Procedure

When an injection is administered that is part of a procedure (i.e. allergy injections, therapeutic and diagnostic radiology, etc.), Medicaid will not pay the administration fee(s).

3.10.1.4 Administration Only of a Injectable/ Vaccine to a Client with Medicare or Other Primary Payer and Medicaid

When billing for a client who has either Medicare or private insurance, and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

Federal regulation requires that the provider who administers the medication must also bill for the cost of the medication. For example, a client may not purchase a prescription at a pharmacy (that bills Medicaid for the drug) and then take the medication to the physician's/osteopath's office to be administered (who also bills Medicaid for the administration fee). Also remember to bill Medicaid the usual and customary charge.

3.10.1.5 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS (Healthcare Common Procedure Coding System), must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each HCPCS medication. This requirement applies to cancer drugs with HCPCS codes, claims submitted electronically and on the paper CMS-1500 claim form. This requirement **does not** apply to Medicare claims which "crossover" to Medicaid as the secondary payer.

The HCPCS medications that require NDC information are listed in the current HCPCS Level II Expert Manual, Appendix 3, alphabetically by both generic, brand or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB 628 – "NDC required."

The collection of the NDC information allows Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program. This requirement is supported by CMS, which encourages all states to develop systems to claim drug rebates due to the Medicaid programs. See State Medicaid Director Letter #03-002, at: **http://www.cms.hhs.gov/states/letters/smd031403.pdf**.

Electronic Claims
For professional providers that use the PES (Provider Electronic Solutions) billing software provided by EDS, HIPAA compliant fields to report the NDC information are available. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information. Call toll-free: (800) 685-3757 or (208) 383-4310 in the Boise area.

To enter NDC data in the PES software, complete the Service and RX tab fields using the following guidelines:

SERVICE Tabs:

Step 1 Complete Service Tabs 1 and 2 as appropriate.

Step 2 Select Service Tab 3 and complete the appropriate fields.

Step 3 Enter "Y" in the RX Ind field to open the RX tab.

RX Tab:

Complete the following fields:

- NDCL: enter the 11-digit NDC number
- Prescription Number: not required.
- Units: enter the units dispensed. Refer to the HCPCS manual, Appendix 3, for brief directions regarding the "Amount" (Unit) column.
- Basis of Measurement: enter IU – International Units, GR – Grams, ML – Milliliters, or UN
- Unit Price: enter the price for the HCPCS medication dispensed

Refer to the PES (Provider Electronic Solution) handbook, Section 9 (837 Professional Forms) for more information on completing the Rx fields. It is available on the Idaho Medicaid Provider Resources CD and can be accessed online at:
http://www.healthandwelfare.idaho.gov/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=4477&MId=11624&wversion=Staging

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims
Submission of an *NDC Detail Attachment* is required with paper claim forms

when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the *NDC Detail Attachment* is available in the Forms Appendix and can be used as a master copy. The form can also be found on page 12 at: **www2.state.id.us/dhw/medicaid/MedicAide/1003.pdf**.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.11 Claim Billing

3.11.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the claim date of service.

3.11.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See **Section 2** for more information on electronic billing.

3.11.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.11.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers. All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.11.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.11.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.11.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.

Field	Field Name	Use	Directions
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the prior authorization number from Medicaid, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an X.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33 GRP #.

Field	Field Name	Use	Directions
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including an explanation of the denial reason.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP# — Group Provider Number PIN # - Individual Provider Number	Required	Enter your nine-digit Group Medicaid provider number. Enter your nine-digit Individual Medicaid Provider number.

3.11.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500